Population Policy

of

Rajasthan

Small Family
Happy Family

Department of Family Welfare
Government of Rajasthan

1999

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Contents

Chief Minister
Rajasthan
December 9, 1999

Foreword

Rapid increase in population is the most burning problem of the country, especially for our state of Rajasthan. This has caused an unending demand for shelter, food, education, health and clothing resulting in increase in poverty, unemployment, food and water shortage and the like. The increased fragmentation of holdings has made the holdings small, uneconomic and insufficient to feed the family, resulting in migration of rural people to urban areas in search of employment. This unlimited growth has also adversely affected the environment of the State.

If the current rate of growth continues, the size of the Rajasthan population will reach 80 million by 2016-an addition of 30 million to its current population size. Rajasthan with its scarce and limited resources may not be in a position to sustain this population. Hence it has become vital today to have a long term and holistic view about population control measures.

This is the basis for the formulation of a Population Policy for the State: to set its demographic goals and to specify the strategy and interventions to attain policy goals and objectives.

This document `Rajasthan Population Policy' is a major milestone in our population stabilization programme and the State Government is committed to its successful implementation.

I commend the efforts of the Family Welfare Department, Government of Rajasthan, the Population Resource Centre, Jaipur, the Futures Group International and the experts associated for bringing out such an important and timely document.

(Ashok Gehlot)

इन्दिरा मायाराम
राज्य मन्त्री
वित्त, आयुर्वेद, परिवार कल्याण
मत्स्य, देवस्थान एवं इ.गा.न.प.
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Preface

The estimated population of Rajasthan in 1996 was about 5 crores, which would grow to 8 crores even if it were to achieve replacement level of fertility by 2016. With limited natural resources at its disposal, Rajasthan cannot afford the continuation of its rapid population growth, since it is not difficult to visualize the quantum jump in the demand for food grains, water and other basic infrastructure to just sustain this level of human population.

Thus there is a growing consensus in the State that the declaration in the rate of growth of population and its qualitative improvement are among the key determinants for sustainable development of the State. To develop a meaningful approach to achieve these objectives, efforts have been made to develop a policy document, a state specific effective population programme.

Accordingly, the State Government has taken the initiative to formulate a Population Policy for the State, to set its own demographic goals and to specify the strategies and interventions proposed to attain policy goals and objectives. It has been realized that investments in the population stabilization programme will have high rates of return not only in the economic sector, but in social and environmental sectors also.

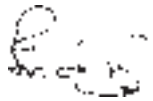
In this document of ``Population Policy for Rajasthan'', efforts have been made to evolve a practical as well as ethically sound and culturally appropriate holistic approach, with particular emphasis on ending gender discrimination and ensuring popular support to meet the objectives of the Population Policy. The policy document focuses on formulation, implementation, monitoring and evaluation of the Reproductive & Child Health Programme. It reflects the commitment of the Government towards the overall welfare of the people of Rajasthan.

The implementation of the policy is the primary responsibility of Family Welfare Department, but it involves the active support and full cooperation of other departments as also of non-government organizations and the private sector.

The policy document proposes such interventions of facilitate such participation so as to transform the programme into a people's programme.

I like to commend the efforts of the Expert Committee set up by the State Government under the Chairmanship of Prof. V.S. Vyas & its members Prof. L.K. Kothari, Dr. G. Narayana, Ms. Sumita Ganguly, R.L. Bajpai & the member Secretary Dr. Ashok Bapna for accomplishing the task well within stipulated time. I do hope that this committee would continue to provide its guidance in the implementation process also.

Our vision is to make the State healthy and safe for all: rich or poor, male or female, young or old.



(Indira Maya Ram)

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Acknowledgment

In the past few years, the continuing high growth of population in Rajasthan, has become a cause for concern, given the serious implications it has for the State's overall socio-economic development. The Population of Rajasthan has increased from 16 million in 1951 to 44 million in 1991 and at this rate will cross 60 million by 2003. The total fertility rate is more than twice that of replacement level fertility which needs to be achieved to realise the goal of population stabilization.

Having realized the impact of such a huge population on the fragile eco-system as well as the quality of life of the people of the State, it was felt that a comprehensive policy and action plan are necessary to achieve the replacement level fertility. In order to initiate the process of population stabilization in the state, the Government of Rajasthan entrusted the task of identifying the key policy issues with the help of workshops and consultations to the Indian Institute of Health Management Research (IIHMR), Jaipur. The Institute conducted two workshops and prepared a report and a draft policy which was submitted to the Government of Rajasthan in March, 1998.

In order to examine this draft policy in terms of its feasibility the State Government constituted a committee with Prog. V.S. Vyas as Chairman, Prof. Lalit Kothari, Dr. G. Narayana, Ms. Sumita Ganguly, Mr. R.L. Bajpai as members and Dr. Ashok Bapna as Member Secretary in April, 1998. It had in all 5 consultative meetings with various experts and senior administrators. Smt. Aditi Mehta, Secretary, Medical and Health (FW) participated in all meetings.

The Committee taking into consideration the proceedings of the workshops conducted by IIHMR and the issues that emerged during consultative meetings, prepared a draft population policy and submitted its report to the Government in December, 1998. The draft report was further discussed in Rajasthan Jansankhya Vikas Parishad meeting and the State Cabinet approved the policy on July 31, 1999.

On behalf of the State Government, I wish to acknowledge all those who have given their constant support at various stages and who have contributed to the policy development process. I would like to particularly thank the Committee members for their keen interest, insight, valuable suggestions and their contribution in the development of population policy.

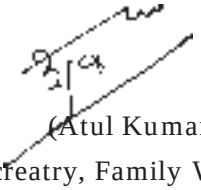
I would like to record my deep sense of gratitude to my predecessors Mr. Ram Lybhaya for initiating the process of preparation of the document, its finalization at the Government level and getting its approval from the State Cabinet and to Mrs. Aditi Mehta for constituting the committee and for getting the draft document approved by the Rajasthan Jansankhya Vikas Parishad.

I am grateful to Dr. G. Narayana, Country Director, the Futures Group International, New Delhi for its close association and guidance from the beginning of the project, for getting the population policy printed both in Hindi and English, for two audio-visuals prepared on policy and for extending support to dissemination of policy contents at state, division and district level.

My thanks are due to the Directors of Medical & Health for their active involvement in preparation of the draft policy. The overall coordination for the preparation of this policy document and its finalization has been done by the State Population Resource Centre (PRC). I thank Dr. Ashok Bapna, Social Scientist and Officer-in-charge of the PRC and his team who extended full and sincere support to the process of policy development.

I am grateful to our State Minister, Family Welfare, Mrs. Indira Mayaram who took keen interest and guided in formulation of this policy document and is equally interested in its proper implementation with a strong commitment to readily converting it into a people's programme.

The Rajasthan Government sincerely wishes to implement all components of the policy and will make all efforts to involve-different departments, Panchayats and other local bodies, non-government organizations, private sector and social workers.



(Atul Kumar Garg)
Secreatry, Family Welfare

1. Introduction

1.1 The high rate of population is a major problem of the Country and the State as well. Population control remains the most challenging task before our nation and our state today. Although India was the first developing country to adopt the Family Planning Programme in 1951, the efforts towards population stabilization in the last five decades did not fetch the desired results. After the 1994 International Conference on Population and Development (ICPD) at Cairo, the country as a whole approaching the issue of population stabilization from a Reproductive Child Health (RCH) perspective. Due to socio-economic and demographic heterogeneity it is, however, not possible to implement all the components of the programme of action adopted at ICPD, in all the states all at once. There is an urgent need, therefore, to take the regional variations into account while developing programmes and action plans that are state specific.

1.2 While most of the Southern States have achieved, or are in the process of achieving replacement level of fertility, North Indian States have a long way to go before they can achieve it. Rajasthan is one of the states where the rate of population growth is still very high According to the 1991 census, the decadal growth rate of population was 28.4 per cent, the highest in the county. Arresting the galloping rate of population growth remains a difficult and challenging task for the State Government. For this purpose intensive and serious efforts are to be taken up immediately.

1.3 It was felt that for an effective population stabilization, the programme must be state specific, and within the state it must be district, tehsil and gram panchayat specific and within gram panchayat family specific. This necessitated the review of the State's programmes and strategies and development of new policy initiatives in this area of great human and social concern. Central to this redesigned strategy is the stress on the holistic development of the family, especially health of the members, as against a simplistic drive to bring about family control.

1.4 It is hoped that by focussing exhaustively on problems pertaining to population rise and corresponding administrative measures, as reflected in this Population Policy of Rajasthan, the problem of population explosion can be controlled more effectively in the specified period.

2. The Need for a State Population Policy

2.1 Population control programmes until now are being implemented by the state as part of the broad national framework. Though the implementation mechanism and the issues they address are quite similar, it is important to consider state-specific policies and programmes that will address geographical, cultural and socio-economic conditions of the state while formulating state-specific policies and programmes. For achieving the goal of population stabilization in the state, it is required to work out and implement programmes at the state, the district, the sub-division, the gram panchayat, the village and the family level.

2.2 Demographic Profile of Rajasthan

2.2.1 Rajasthan's population was 4.4 crores in 1991 and this increased to 5 crores by the middle of 1996. If this pace of population growth continues, the state's population will cross the 6 crore mark by the year 2003.

Trends in Population Growth: Rajasthan

Population Size	Year of Achieve-ment	Years taken in reaching	Average annual growth (in lakhs)
First crore	1898	-	-
Second crore	1961	63	1.6
Third crore	1977	16	6.2
Fourth crore	1988	11	9.1
Fifth crore	1996	8	12.5
Sixth crore	2003	7	14.3

Looking at the young age structure of the population, it is likely that the population will increase in the future even if the fertility rate comes down in the coming years. As a matter of fact, 40 percent of the state's population is below the age of 15 years and 47 per cent of the female population is in the reproductive ages.

2.2.2 According to the present estimates, Rajasthan will achieve total fertility rate (TFR) of 2.1 by the year 2048 which means that on an average each woman will have two children in her life time. Reaching TFR of 2.1 will initiate the process of population stabilization. If this happens, the state's population will be more than 10 crores by the year 2051. The impact of such an increase in population on the weak economic system and lives of the people is quite understandable.

2.2.3 It has to be emphasized that according to 1991 census, the state is having less than one per cent of available water resources in the country, while 5 per cent of country's population live here. This will place tremendous pressure on the natural resources and even providing

water to the human and livestock population will be a difficult task.

2.2.4 In the face of this stark reality of a rapid population growth and given the social context, it is absolutely imperative for the state that the population growth be brought under control in the least possible time.

2.3 It is obvious that the policies and programmes of the state need reconsideration, and a new population policy has to be developed and implemented. As per the definition, population policy is a well-concerted effort of the Government to bring about changes in the size, structure and distribution of population for improving the living standard of the people. Such a policy will not only indicate clear and qualitative demographic goals to be achieved within a given time limit, but also state the proposed interventions and innovations for achieving these goals.

2.4 In a democratic country like India, where coercive policies are prohibited, the Family Planning Programme has to play a major role in bringing down the birth rate and reducing the average size of family to a desirable level, which is difficult in an environment where the majority of the population, particularly females, is illiterate and the age at marriage is also very low. The fertility rate remains high also because children are treated as economic assets, which makes large families desirable. Hence while formulating population policy, the social, the cultural, the economic and the political context of the state have to be kept in mind.

2.5 The International Conference on Population and Development (ICPD) held in 1994 had called upon to adopt a comprehensive and more realistic population approach with a focus on reduction in fertility rate and, encompassing various issues related to population and reproductive health problems, which affect the women in particular. It laid emphasis on making men more responsible in their reproductive and sexual behaviours. For this it is important to integrate reproductive health approach with various initiatives of population policy.

2.6 In the light of these realities, it was felt necessary to formulate a population policy consistent with national health and population policy.

2.7 Underlining the significance of a workable population policy, Dr. M.S. Swaminathan said, “If our population policy goes wrong, nothing else will have a chance to go right.”

3. Demographic Problems

3.1 Possible Trends in Population Growth of Rajasthan

The following table gives an estimate of the size of the state's population in the coming years. It shows two different scenarios. First scenario is based on the assumption that the TFR of 2.1 will be achieved by the year 2048 while the second scenario assumes that TFR of 2.1 will be achieved between the years 2011 and 2016.

3.1.1 Rajasthan's population according to the first scenario, will cross the 6 crore mark by the year 2003. If this pace of growth continues, the state is likely to double itself in the next 30 years. In this situation, Rajasthan will be able to reach replacement level of fertility in 2048 -which is the beginning of the population stabilization process. The population of the state however will increase and will be 10 crores in 2051. Thus, it is not difficult to visualize the consequences of rapid population growth on the natural resources and living standards of the common people in the state. In view of the seriousness of the situation, Rajasthan Government has decided to stabilize its population between 7.5 and 8.0 crores by reaching replacement level fertility by 2016. Though it is a difficult task, it can be achieved if the unmet need for family planning services (30 per cent) is fulfilled by the year 2006. This will result in reducing unwanted births, and as a result the fertility levels will come down and facilitate in reaching replacement level of fertility.

Rajasthan's Population: Possible Trends

(in crores)

Year	First Scenario	Second Scenario
1996	4.96	
2001	5.59	5.51
2006	6.23	5.90
2011	6.88	6.23
2016	7.39	6.40
2021	7.94	6.76
2026	8.45	7.10
2031	8.95	7.36
2036	9.42	7.54
2041	9.88	7.67

3.2 Density of Population

The population density in the state indicates that the pressure on the natural resources is steadily increasing. In the beginning of the century, 30 persons lived in one sq km area. By the time of independence, this figure had increased to 47 persons per sq km. In 1981 census, the density of population was 100 persons per sq km. that further increased to 129 persons in 1991.

Going by the present trends, it is estimated that by 2001, the population density of Rajasthan will reach 164 persons per sq km. Even though population density of the state is lower than the

national average, it has to be kept in mind that two-thirds of the state is arid and semi-arid where the human habitation is very sparse. Consequently, the increase in population density in the rest of the state will place tremendous strain on the already scarce natural resources.

3.3 Sex Ratio

The 1991 census gives a dismal picture of the state in terms of its sex ratio. The sex ratio that was 921 females per 1000 males in 1951 had decreased to 910 females per 1000 males in 1991. This is less than the national sex ratio of 927 females per 1000 males. The continuously decreasing sex ratio reflects the declining social status of women in the state and that has further consequences on female literacy, age at marriage, fertility and maternal mortality.

3.4 Reproductive Behaviour

3.4.1 Reproductive behaviour is influenced by a complex set of socio-cultural and economic factors. Currently, married women in Rajasthan have 4 to 5 children and the current fertility level is considerably above the replacement level of fertility of 2 children. The total fertility rate in Rajasthan declined from 6.3 in 1971 to 4.4 in 1997.

Population Density in Rajasthan: 1901-2001

Year	Population Density (in sq km.)
1901	30
1951	47
1961	59
1971	75
1981	100
1991	129
2001	164 (Estimated)

Likewise, the crude birth rate declined from 42.4 per 1000 population to 32.1 during the same period. The exponential growth rate of 2.85 per cent declined to 2.5 per cent in 1995. All these are positive trends but the pace of decline is too slow to have the desired impact on development indicators.

3.4.2 Fertility behaviour is partly determined by the age of effective marriage. Rajasthan has about 25 lakh women in the age group of 15-19 and, of these, 44.6 per cent or 11 lakh women are effectively married. 79 per cent of currently married women in age group of 20-24 were married before reaching the legally prescribed age of 18 years. The median age at effective marriage is 15 and 19 years for women and men respectively. The low age at effective marriage not only increases the active reproductive life span, but also results in teenage pregnancies that can have adverse consequences to the health of mothers and children. Statistics show that one out of six women in the age group of 15-19 years has a child before reaching age 20 and nearly 1.8 lakh women give birth to their first child during their adolescent years.

3.4.3 Pregnancy wastage is estimated to be 6.9 per cent of total births. As per the NFHS estimates, 3.2 per cent pregnancies result in spontaneous abortions, 1.1 per cent in induced abortions and 2.6 per cent in stillbirths. Survey estimates of abortions are always extremely low and are, therefore, unreliable. Other indirect estimates of induced abortion project the number of abortions in Rajasthan at 350,000 per year, which is several times higher than the

actual reported number. A large percentage of abortion services are provided by untrained and unqualified persons and are unsafe.

3.5 Maternal and Child Health

3.5.1 Innumerable studies have indicated a close relationship between fertility and mortality particularly maternal, infant and child mortality. As per 1991 census, 11 crore children in India and 64 lakh children in Rajasthan are in the age group of 0-4. The child mortality rate in Rajasthan is 40 as compared to 31 in the country. Likewise, the infant mortality rate for India was 74 in 1995 whereas in Rajasthan it was 86. During the last seven years, the pace of decline in infant mortality rate has been slow and the major reasons for high infant mortality are inadequate antenatal and postnatal care and lack of facilities.

3.5.2 According to the Registrar General of India's "*Sample Registration Scheme-1997*", the maternal mortality rate is estimated at 677 per 100,000 live births. Corresponding figures for both Kerala and Punjab were 195 and for Maharashtra it was 135. For adjoining states of Haryana and Madhya Pradesh, these figures were 105 and 498 respectively. Only Uttar Pradesh with maternal mortality rate of 707, has higher rate than Rajasthan.

3.5.3 High infant and child mortality rate in Rajasthan is a cause of concern. Sixty per cent of infant deaths include deaths of new born. Reasons for majority of these newborn deaths are due to premature deliveries, illiteracy, poverty, lower socio-economic status of women, and lack of proper care during pregnancy at younger ages, availability, quality and utilization of antenatal services and assistance by trained at the time of delivery. Apart from these main reasons, acute respiratory infection, diarrhoea, pneumonia, infection in umbilical chord, etc. also account for infant deaths while malnutrition, immunization not given as per schedule and discrimination against girl child are major factors for childhood mortality.

3.5.4 Children in large numbers suffer from chronic and severe malnutrition. Two-fifths of them are underweight or dwarfs for their age. Among them, 19 per cent of the children are suffering from severe malnutrition according to 'weight for age' and 27 per cent according to 'height for age' criterion.

3.6 Family Planning

Several studies have shown a positive relationship between female literacy, contraceptive use and other health indicators. According to these studies, it is found that female literacy influences fertility behaviour and contraceptive use. For instance, in Kerala where women are highly educated and literacy rate is 86.2 per cent, the couple protection rate is 48.8 and the crude birth rate (CBR) is 18.0. In Tamil Nadu where female literacy is 51.3, the couple protection rate is 53.5 and the crude birth rate is 20.3. For Punjab the corresponding figures are 50.4, 81.2 and 24.6 respectively. On the other hand States with low female literacy rate presents a different picture. In Uttar Pradesh where the female literacy is 25.3 per cent, the couple protection rate is 40.7 and the crude birth rate is 34.8. Correspondingly in Bihar, it is 22.9,

23.1 and 32.1 respectively. Likewise in Rajasthan, which has the lowest female literacy of 20.4 per cent, the couple protection rate is only 30.7 and the crude birth rate is 32.1. This shows that states having higher female literacy rate have a higher couple protection rate and a lower crude birth rate. Further among educated couples not only the couple protection rate is higher, but the percentage of spacing method users is also higher. Thus the use of contraceptives has increased with increase in educational level and awareness. Unfortunately, the educational level, particularly the educational level of women is much lower in Rajasthan. As a result, birth rate is much higher and the couple protection rate is just 30 per cent.

3.6.2 The contraceptive prevalence rate in Rajasthan for all methods increased from 5.2 per cent in 1971 to 31 per cent in 1993, an increase of 1.2 percentage points, on an average, per year. Of the total current users of modern methods, 87 per cent use sterilization methods while only 13 per cent use spacing methods. In addition, one per cent of eligible couples use traditional methods such as periodic abstinence and withdrawal. The use of contraception in urban areas is higher (42 per cent), compared to rural areas (27 per cent). Nearly 42 per cent of sterilization users have 4 or more children; 39 per cent, 3 children; and 19 per cent, 2 or fewer children. The impact on use of sterilization methods on decline in fertility rate is low, due to acceptance of the method by high age and parity couples.

3.6.3 Innumerable reasons such as strong preference for sons, fear of side effects, and lack of access to quality services, low status of women and traditional beliefs, are responsible for the low acceptance of family planning. Higher incidence of poverty, in both rural and urban areas, coupled with illiteracy, also work in favour of large families, where everyone is expected to earn, irrespective of age, sex and skills.

3.7 Reproductive Tract Infections (RTIs)

3.7.1 Reproductive Tract Infections among men and women is an area of major concern in the state. There is no information available on prevalence and incidence of reproductive tract infections. A few recent studies followed the syndromic approach to identify symptoms and used the services of field workers for diagnostic purposes.

3.7.2 In a study conducted in Bundi district, 47 per cent of a total of 2,752 women examined, reported one or more symptoms of reproductive tract infections. Reported RTI symptoms were higher among young women in lower socio-economic categories. Only 30 per cent of women with symptoms sought services of health professionals for treatment. In contrast to this, of the total 442 men interviewed, only 17 per cent reported RTI symptoms. The higher rate of RTI among women could largely be due to denial or non-availability of services.

3.7.3 Although the findings of one micro level study is not sufficient to draw a general

conclusion, it is safe to assume that RTIs are higher among women than men and are higher among lower socio-economic categories.

3.7.4 Female education, facility for drinking water and sanitation are the major factors in population control. Although female literacy has improved over time, lower female literacy rate of 20.4 per cent as reported in 1991 census is a matter of concern. Therefore under the ninth plan of the state, it is envisaged to have primary schools in radius of one km. in tribal areas, arid and frontier zones. A target of providing safe drinking water to settlements of 5,000 population annually, has also been worked out under the plan.

We hope to have positive results of these efforts.

3.8 Ill Effects of Rapid Population Growth

The rapidly increasing population of the state is having an adverse impact on socio-economic development and environment.

- Food grain production is not sufficient for increasing population in Rajasthan. Due to rapid increase in population, the availability of food grains per capita has reduced. The annual per capita food grain availability (including pulses) that was 241 kgs. in 1961 has come down to 192 kgs in 1991. If the population continues to increase according to the first scenario, the nutrition situation of the state is bound to become grave in the near future. It is estimated that the prevalence of chronic and severe malnutrition is higher in Rajasthan. According to an estimate, 14.3 per cent children below 3 years and 13.8 per cent infants between 6 and 12 months are suffering from severe malnutrition and 34 per cent children below 3 years from mild malnutrition.

- The increasing population will put more pressure on land and other facilities that in turn will result in more tension and violence in the society. The land holding per household at the time of independence was 11.30 hectares in the state and it has come down to 4.11 hectares in 1991 due to rapid increase in population.

- Housing problem will reach a menacing proportion in both rural and urban areas. It is estimated that in 1981 there was a shortage of 233 lakh houses in the country and this will increase to 638 lakhs in 2001. In Rajasthan, there was a shortage of 10.5 lakh houses in 1981 and has now increased to 21.4 lakh houses. With rapid urbanization and population growth, huge investments will be needed to provide housing facilities in urban areas alone.

- Sanitation facilities are not available to almost half of the urban population and nearly the entire rural population in Rajasthan. If the population grows at the same rate then, it will be an arduous task to provide these facilities.

- Clean and safe drinking water is a must for the prevention of water borne diseases.

Rajasthan, being mostly in an arid zone, has scarcity of water. Only one per cent of country's water resources are available with the state. If the population goes on increasing at the present rate, in another 2-3 decades there will be severe crisis of water, particularly, safe drinking water.

- It is estimated that, by the end of the century the country will have 50 crore illiterates, almost half of the total illiterates in the world. Rajasthan has 43 lakh illiterates in the age group 15-25, of which 30 lakh are women. Percentage of female literacy in Rajasthan (20.4) is the lowest in the country. Thus, with increasing population, the number of illiterates will also increase.

- Increase in unemployment is expected because of rapid population growth. Between 1991 and 2001, the labour force is expected to increase to 631 lakhs. In Rajasthan, nearly 3.5 lakh people enter the job market every year. With increase in population, nearly 4.5 lakh newer jobs will have to be created each year from 2001 onwards. With the participation of women in labour force expected to increase, the above figures might go up further resulting in discontentment with the system.

- Number of people living below poverty line will also increase. Currently 29.2 per cent of the country's population is estimated to be below the poverty line while in Rajasthan it is around 23 per cent. With increase in population there is hardly any possibility of reducing the number of people below poverty line.

- The natural resources will be under tremendous pressure and will result in deforestation and increase in desert zone due to increase in population. This ultimately will lead to recurrence of natural calamities like famines, floods, pollution of air and water and thus result in environmental degradation.

4. National Demographic Goals and Present Status

4.1.1 In spite of widespread efforts backed by the provision of resources by the Government of India, the family welfare programme has not been able to bring down the fertility rates to desired levels in the last four decades. Although a large number of births were averted (30 lakh births between 1971 and 1991) and 30.7 per cent eligible couples have been covered through family planning, the crude birth rate (CBR) is still as high as 32.1. If this birth rate is compared with birth rate of 17.9 in Kerala, 23.4 in Punjab and 25.6 in Gujarat then Rajasthan comes in the category of low performing states.

4.1.2 The following table compares the position in Rajasthan and few other states against the national objectives formulated for the year 2000.

4.1.3 The following table gives a clear picture on how Kerala has achieved the objectives set for the year 2000 much earlier, and how close Gujarat is in achieving it in comparison to Rajasthan. Due to better educational status of women, greater access of people to health and family planning services and firm political and social commitment for a small family norm, Kerala and Gujarat have been able to either achieve or move closer to the set national goals.

4.1.4 The state government's efforts will be to attain the demographic goal fixed for the year 2000. Over a period of time, Rajasthan will endeavor to match the position in Kerala, by bringing down the population growth rate and lowering the fertility and birth rates.

Indicator	Targets Fixed for the year 2000	India	Rajasthan	Gujarat	Kerala
A. Natural growth rate (%) – 1995	1.2	1.93	2.41	1.91	1.17
B. Birth Rate - 1997	21.0	27.2	32.1	25.6	17.9
C. Death Rate - 1997	9.0	8.9	8.9	7.6	6.2
D. Infant Mortality Rate - 1997	Less than 60.0	71.0	85.0	62.0	12.0
E. Maternal Mortality Rate (per 1000) - 1997	Less than 2.0	4.08	6.77	NA	1.95
F. Couple Protection Rate (%)	60.0	46.5	30.7	59.5	48.8
G. Total Fertility Rate-1993	2.3	3.5	4.5	3.2	1.7

NA: Not Available

5. Population Stabilization : Goals

5.1 Family Welfare Programme is inseparably linked with other sectors and demands intervention and efficient policies in these sectors so that changes can be brought in the social, economic, cultural, and political environment. Therefore, the objectives set by the Family Welfare Department and other related departments that are playing an important role in this area can alone determine the objectives of population stabilization.

5.2 Goals

The goal has been set to achieve replacement level fertility by the year 2016. Though it is difficult, it is essential to attain the objective. With this in view, the rate of contraceptive use has to be increased to 68 per cent by the year 2016. If this objective is not achieved, then as mentioned before, the population explosion will continue and at the time of the 2051 census the population of the state will reach 10 crores which will have adverse effects on the living standards of the people.

5.3 Age at Marriage

- To educate adolescent girls and boys about right age for marriage and responsible parenthood.
- Increase awareness of legal age at marriage from 20 per cent in 1993 to 80 per cent by 2005.
- Increase the average age of marriage of girls from 15 years in 1993 to 18 years by the year 2010.

5.4 Reduction in Maternal Mortality Rate (MMR)

- Improve antenatal services by increasing the proportion of pregnant women receiving IF A tablets from 49 per cent and TT injections from 43 per cent in 1996 to 90 per cent by 2010.
- Make antenatal services accessible to all pregnant women and ensure their examination for early detection of risks associated with pregnancy.

Indicators	1997	2001	2004	2007	2011	2013	2016
Total Fertility Rate	4.11	3.74	3.41	3.09	2.65	2.43	2.10
Birth Rate	32.1	29.2	27.5	25.6	22.6	20.9	18.4
Contraceptive Prevalence Rate	38.5	42.2	48.2	52.7	58.8	61.8	68.0
Death Rate	8.9	8.7	8.4	7.9	7.5	7.2	7.0
Infant Mortality Rate	85.0	77.4	72.7	68.1	62.2	60.1	56.8

- Increase institutional deliveries from 11.6 per cent in 1995 to 50 per cent by 2016.

- Expand emergency and obstetric care services.

- Provide safe abortion services in 75 per cent of the primary health centres by the year 2016.

- Increase assistance at delivery by trained persons from 33 per cent in 1995 to 100 per cent by 2005.

5.5 Reduction in Child and Infant Mortality Rate

- Eradicate polio by ensuring 100 per cent coverage of children by 2000.

- Provide full immunization coverage from 38 per cent in 1996 to at least 90 per cent of children in 2007.

- Ensure 90 per cent use of ORS for diarrhoea control by 2007.

- Reduce incidence of acute respiratory infection by 70 per cent by 2003.

- Increase capacity of correct diagnosis and management of diarrhoeal diseases at sub-centre level to 70 per cent by 2007.

- Ensure that 70 per cent children get five doses of Vitamin A by 2007.

- Eliminate chronic and severe malnutrition among children as soon as possible and increase birth weight of children.

5.6 Reduction in Fertility Rate

- Educate all the eligible couples about the contraceptive choices available, and encourage them to take responsible decisions.

- Promote spacing method use by encouraging couples to have first child after two years of marriage; second child after 3-5 years of the first one and then to promote terminal methods to those couples having two or more children.

- Encourage males to share responsibility and increase the use of contraceptive methods especially male sterilization.

- Increase age of woman at first birth from 16.2 to 20 years as early as possible.

5.7 Reproductive Tract Infections

- Document prevalence and incidence rates of reproductive tract infections in different parts of the state.

- Reduce the prevalence rate of reproductive tract infections substantially with special emphasis on women in lower social and economic groups.

- Create awareness and educate people on HIV / AIDS and provide counseling services.

5.8 Infertility

- Provide counseling and clinical services to couples facing the problems of infertility.

5.9 Goals for other Departments

- Ensure that women enjoy social, economic and political rights.

- Raise female literacy rate from the present rate of 20.44 per cent

- Ensure that mean age at marriage for women is increased from 15 years in 1993 to 18 years.

- Reduce severe and mild malnutrition among women and children.

- Reduce prevalence of child labour among children below 14 years.

5.10 The expectations are that through this new population policy of the state government, the objective of a small and happy family will be achieved. This policy will make it possible to considerably reduce population growth rate and as a result will provide more opportunities for employment, provide basic necessities to the people, and ensure steady economic development. On the personal level, small families will mean the availability of better educational and health services, and improvement in the nutritional status. Consequently, women's health will improve and there will be less infant and child mortality. Fewer children will also ease the pressure on housing, check the fragmentation of agricultural land, and help to conserve scarce natural resources.

5.11 In brief, by controlling population growth, it will be possible to tackle the problems of housing, forests, drinking water, education, environment, transport, etc. Small families will mean better educational and health services, smoothening the path of economic development, which in turn will mean happier and better standard of living of the people, and the consequent increase in production and income.

5.12 To achieve these objectives, the family welfare programme will have to be made a people's programme so that an atmosphere is created in which every person has a firm conviction that a small family is a happy family.

6. Operational Strategies for Implementation of Population Policy

6.1 For the achievement of the population policy objectives, the following strategies will be adopted:

- Preparation of a package of Reproductive and Child Health Services in accordance with the Cairo Convention.
- Improving the management of service delivery systems.
- Creation of an atmosphere that will nurture a positive attitude for small family norm.
- Encouraging participation of panchayat raj institutions, voluntary organizations, private sector, cooperatives and other organizations to play a role in social awakening and making these institutions partners in the programme.

Although most of the strategies are to be implemented by the medical, health and family welfare department, inputs of other departments like women and child development and education with regard to some strategies will be needed. IEC interventions are an integral part of several strategies.

6.2 Creating Conducive Environment for Small Family Norm

6.2.1 To instill determination for a small family, it is essential to create a proper social environment. Taking the initiative in this direction, the Rajasthan Government has set afoot, several efforts, which include provision of primary education to all children, especially girls, empowerment of women and improvement in their status, constitutional provisions to bar people who have more than two children from contesting elections of specific bodies, and ensuring gender equality. The collective benefits of all these efforts will bring about a qualitative improvement in the life of the people of the state.

6.2.2 Female Literacy

6.2.2.1 The relationship between female literacy and fertility, contraceptive use and reproductive and child health is well established. According to the 1992-93 NFHS, the female literacy rate was only 25 per cent of which 15 per cent had formal education. Further in 1993-94, it was found that the proportion of girls dropping out at the primary school level was 67 per cent while it was 73 per cent at the middle school level. Efforts have been made to

improve the situation with regard to girl's education through schemes like *Saraswati Yojana, Guru Mitra Scheme, Lok Jumbish, Shikshakarmi and District Primary Education Programme (DPEP).*

6.2.2.2 The main initiatives to raise the level of female literacy will be as follows:

- Law for compulsory primary education.
- Establishment of schools for only girls wherever necessary.
- Fixation of school timings to suit local needs and circumstances.
- Specific interventions to overcome obstacles in girl child education.
- Priority for the inclusion of women aged 15-25 under the total literacy programme.
- Vocational training to girls after primary level to enable them to earn and make them economically self- reliant.
- Inclusion of women's reproductive health in the curricula of women's education programmes at proper level.

6.3 Information, Education and Communication (IEC)

6.3.1 Identification of the family welfare programme with sterilization has been a common feature until now. The approach in the past was "target oriented" and hence numerical targets influenced the work culture of programme personnel. IEC therefore, can play an important role in changing the mind-set of the programme personnel and educating the people about the present client oriented approach and the concepts of RCH. Further programme aspects such as increasing the age of marriage, delaying the first pregnancy, spacing between two pregnancies, adoption of terminal methods after two or more children, women's education and awareness, responsibility of the males in reproductive behaviour and determination to have a small and happy family are the main points that will be propagated through IEC.

6.3.2 Following strategies will be adopted:

- increase and make effective use of radio, doordarshan and other television channels.
- make effective use of visual media including cinema.
- ensure active participation of the religious, political and educational leaders.
- include subjects of population and reproductive health in various formal and non-formal educational programmes.
- promote local-specific IEC
- involve professional agencies in this endeavor.
- conduct periodical assessment of innovative interventions.

- improve inter-personal and IEC skills of health workers and doctors.

- formulate separate plans for remote and inaccessible and low performing areas.

- develop decentralized district level plans.

- establish district level IEC bureaus.

- use IEC resources of other departments.

- involve *Jan Mangal* couples in IEC activities.

Family will be the focal point of this strategy and efforts will be made to motivate every eligible couple to adopt a small family.

6.4 Age at Marriage

6.4.1 It is a well-known fact that the health status of women and their fertility behaviour are influenced by the age at which they marry. The prevalence of child marriages in Rajasthan poses a serious challenge. On an average, women in Rajasthan marry around 15 years and have their first child at 16.2 years. The social system, the feeling of insecurity, traditional practices and customs, superstitions and illiteracy are the main reasons for child-marriages.

6.4.2 Observance of the legal provision for the minimum age of marriage is difficult against this backdrop. The strategies to meet these challenges are as follows:

- Integrated and concerted action by all departments concerned, such as home, social welfare, women and child development, education, health etc.

- Delegation of powers to local administrations, panchayats, municipal boards to enforce the legal age of marriage and make them accountable for it.

- Legal registration of marriage.

- Observance of the minimum age of marriage to be made compulsory for availing of government facilities and services.

- Stiffer penal provisions for violation of the legal age at marriage.

6.5 Gender Equality and Women's Status

6.5.1 Rajasthan is a very backward state from the point of view of male-female equality. Some examples make the sad plight of women quite clear, such as female foeticide, large percentage of girl dropouts from school, marriage at very young age, malnutrition, discrimination in diet and health care, low participation in secondary and tertiary occupations, decisions on child bearing by the male or other family members, and domestic violence. The factors behind this situation are lack of economic independence, illiteracy, orthodox and superstitious rites and rituals, and a male dominated society. The empowerment of women is vital for social development and harmonious family relationship.

6.5.2 An all-inclusive comprehensive policy is necessary for the empowerment of women.

With 30 per cent reservation for women in panchayats and municipalities, the reform process has already started by ensuring.

6.5.3 The following measures are necessary for improving the status of women and empowering them, and efforts will be made in this direction:

- Making primary education compulsory for all girls.
- Reducing the drop out rate of girl students
- Promotion and propagation of non-formal and vocational education to women
- Strict enforcement of the legal age of marriage and increase in the average age of the woman at the time of first delivery.
- Increasing the participation of women in secondary and other economic sectors.
- Ensuring strict enforcement of Sarda Act, Pre-Natal Diagnostic Technique Act, 1994 (Regulation and Prevention Act, 1994), Dowry Act and violence against women, and speedy dispensation of justice.
- Concerted efforts to improve coordination and cooperation of government departments, social institutions, voluntary workers and community leaders.

6.6 Awards

6.6.1 There has been a practice of giving monetary incentives to providers for motivating sterilization clients. However, it was found through experience that there were instances where incentives were often misused. A policy decision, therefore, has been taken to discontinue the incentive scheme. It is worth mentioning that even after incentives in cash or kind were withdrawn, there was no decline in the number of sterilization operations performed.

6.6.2 It is thought that while preventing the misuse of incentives, it will be useful to give symbolic awards for good performance and initiate efforts to minimize laxity and negligence.

6.6.3 A good example can be seen in case of panchayati raj institutions / municipalities where the candidates having two or more children are ineligible to contest elections. This provision has found wide support. The same provisions can also be considered for other elected bodies like cooperative institutions and as a service condition to state government employees.

6.6.4 The following are some of the alternative symbolic steps:

- Provision of certificates of excellence at the district level to various classes of government employees, and voluntary and social organizations for outstanding achievements.
- Wide publicity and propaganda of the Rajlakshmi scheme.
- Linking part of the sanctions of various

developmental works / schemes with the level of achievement of the population policy.

6.7 Contribution by Various Development Sectors

6.7.1 Although this policy has been formulated by the state government, it is recognized that it will neither be possible nor feasible for only the state or its apparatus to implement it successfully. Therefore, it will be inevitable to associate with its implementation non-governmental and voluntary organizations, private sector, social and community organizations, and political leadership. To enable this, the contribution of various stakeholders, its processes and systems needs to be defined.

6.7.2 Panchayat Raj Institutions/ Municipalities

6.7.2.1 The legal provisions barring people with more than two children from election to panchayats and municipal bodies is a testimony of the firm political will and commitment towards population control. Together with this, the reservation of 30 per cent seats in these institutions for women candidates is a significant step in the direction of empowerment of women. There are 119,419 elected representatives in panchayati raj institutions, of whom 38,791 are women and 38,804 belong to Scheduled Castes and Tribes. Effective involvement of these elected local body representatives is crucial for successful implementation of population policy. These representatives with status and prestige in the society can influence and change the thinking of the common people. Besides, linked to the grassroots as they are, they can play an effective role in evaluating the programme and making the administrative apparatus aware of the difficulties experienced in its implementation. For this purpose, they will be introduced to the programme through training / workshops at various levels. In order to associate them formally with the programme, their responsibilities will be determined through the block-level population committees.

6.7.3 Non-Government/Voluntary Organization

6.7.3.1 Voluntary organizations can play an important role in facilitating the government in implementing innovative schemes for service delivery as they have informal ways of functioning, flexibility and close contact with the people. Further, they can also help in streamlining government strategies and implementation of government programmes.

6.7.3.2 About 360 voluntary organizations are active in various development fields in Rajasthan. Of these, two-thirds are located in Ajmer, Bharatpur, Bikaner, Jodhpur, Sawai-Madhopur, Udaipur and Jaipur districts. A large proportion of these voluntary organizations are active in urban areas, and only a few in rural areas. Most of them are engaged only in training activities instead of activities concerning service delivery. Therefore, in rural areas, voluntary organizations, instead of working as an alternative system to the government can play a complementary role to the government's programme. Rajasthan has very few organizations that have achieved a

high degree of success. The department will encourage these organizations in programme planning, implementation, monitoring and evaluation. These voluntary organizations will also cooperate in training, providing services and building consensus at the local level.

6.7.3.3 The Ministry of Health and Family Welfare (MOHFW), GOI has recently given a new shape to its programme on voluntary organizations and decentralized the administration of voluntary schemes. In accordance with the Government of India's decision capacity building of voluntary organizations will be taken up along the lines of the technical assistance. In every state, mother agencies will be made responsible for identifying and selecting local organizations to monitor the implementation and achievements of new projects. The process of sanctioning of projects has been simplified. With these changes, there will a marked increase in the number of projects to be implemented by voluntary organizations. The department will fully cooperate with this programme of the GOI and adopt a similar approach towards the projects run with state government funds by voluntary organizations.

6.7.3.4 In the districts, the Nehru Yuva Kendras (NYKs) and similar such youth organizations will be involved in IEC activities.

6.8 Private/Corporate Sector

6.8.1 In 1996, Rajasthan Government, initiated a policy of private investment in medical institution to ensure the participation of private / corporate sector for augmenting the available medical services. Under this programme, the government not only provides land for setting up of hospital, but also sanctions an investment grant. The private hospital benefiting from this scheme is expected to reserve 10 per cent of the beds for economically weaker sections. These hospitals are encouraged to give priority attention to problems concerning women and children. Initially, participation of private / corporate sector will be ensured at the district / headquarters in urban areas and will be extended to block level in the future.

6.8.2 Private hospitals offering limited services will be given an attractive package of incentives. To set quality standards and determine the rules of conduct in the private sector hospitals, a regulatory authority will be established and a system of accreditation will also be determined.

6.8.3 Many large private industrial houses have their own hospitals and dispensaries with well-trained health specialists. They will be encouraged to set up reproductive health and family welfare Centres for providing services to nearby rural areas. The department in addition will give incentives to industries providing outreach services in rural areas and to those interested in setting up outreach units.

6.9 Cooperative Societies and Other Institutions

6.9.1 There are about 77 lakh members enrolled in 20,000 cooperative societies in the state. In addition, there are women cooperative societies

that have 42,000 members. These societies and their members will be involved as motivators, depot holders and also in social marketing.

6.10 Partners in Programme Implementation

6.10.1 The department will make voluntary organizations, private sector, ISM practitioners, cooperatives, social workers, panchayat raj institutions, women, academicians, representatives of corporate organizations and functionaries of other departments its partners' and seek their help in programme planning and implementation.

6.10.2 Various donor agencies have helped Rajasthan in improving the quality of reproductive and child health services, establishing new institutions providing services, strengthening training system and providing facilities for starting innovative activities. The department expects continued help from these agencies in the future as well.

6.11 Effective Management of Family Welfare Programme

6.11.1 The family welfare programme will be implemented within the framework of the RCH approach and quality services will be made available according to the need and intention of the individual. For successful implementation, the family welfare programme will be made a people's programme.

6.11.2 Promoting Responsible Parenthood

Of the total population of Rajasthan, adolescents between 10 and 19 years constitute 20 per cent. The attainment of the objectives of the population policy will mainly be affected by the knowledge and attitude of these adolescents about reproductive health, particularly human reproductive biology, contraception, menstrual health among women and reproductive tract infections. Many studies conducted on adolescents have shown that the level of information and knowledge is low, but have a strong desire to learn. It is therefore imperative to provide correct information on various aspects of responsible parenthood to adolescent boys and girls.

- The state will endeavor to educate boys and girls on human reproductive system, health systems, and responsible sexual behaviour. For this, proper reforms will be made in the school curricula. However for those not receiving formal education, efforts will be made to share this information through non-formal education channels or voluntary organizations.

- The non-governmental and voluntary organizations will be encouraged to integrate programmes on responsible parenthood with their ongoing developmental activities.

- Electronic media, especially television, which has the widest reach compared to other media, will be used to telecast, in a socially-acceptable form, information about responsible parenthood. Further, a special cell for tele-counseling will be established in each district through non-government / voluntary organizations.

6.11.3 Safe Abortions and Post-Abortion Care

6.11.3.1 The Medical Termination of Pregnancy Act was enacted by the GOI in 1971 to help pregnant women choose abortion services in case of danger to life, grave injury to physical and mental health, pregnancy caused by rape, substantial risk if the child was born and failure of any contraceptive device or method. The proportion of unwanted fertility in Rajasthan is 14 per cent.

6.11.3.2 For those choosing to terminate pregnancy, safe abortion services are still not easily accessible in the state. Lack of equipment and trained manpower in health institutions significantly contribute to inaccessibility. Under such circumstances, women often seek help from quacks, many of whom are unqualified and unskilled to provide such care. Studies indicate that 30 to 40 per cent of all maternal deaths are due to unsafe abortions and complications thereof. To address this critical need, women who experience unsafe abortions must have services readily available to avert life-threatening complications.

6.11.3.3 Besides post-abortion care, the problems associated with unsafe abortions can be tackled to a large extent by providing access to safe abortion services. Abortion service is not a mere clinical service, but requires a humane approach by service providers. Termination of pregnancy has several social and psychological costs associated with it. Counseling services, therefore, should be an essential component at both abortion and post-abortion phases. Post-abortion services should include information on contraceptive choices available and encourage women to use contraception.

- The department intends to reduce the need for abortions by ensuring that all couples wishing to space or limit births have access to quality family planning services.

- The department will give highest priority to provide safe and quality abortion services and post-abortion care at all recognized community health Centres and block level primary health Centres. This will be accomplished by training an adequate number of medical professionals, using the training facilities available at all medical colleges, district hospitals and recognized private institutions in the state.

- Recognition will be accorded to more health institutions based on the recent guidelines issued by the GOI.

- Post-abortion care and safe abortion services will be made available at all primary health centres over the next 10 years. All the doctors of PHCs will be given training on safe abortion and all the PHCs will be provided with necessary equipment and resources in the coming 5 years.

- Access to abortion services will also be ensured through private hospitals.

- Efforts will be made to ensure participation of non-governmental/voluntary

organizations to impart counseling services training for abortion to health functionaries at PHC level.

6.11.4 Antenatal and Post-natal Services

6.11.4.1 Utilization of antenatal services in Rajasthan is low due to lack of awareness of available services and also due to lack of felt need for such services. Female health workers can play a vital role in increasing demand for services and also in providing services such as TT injections and iron folic acid tablets. Availability of female workers at village based clinics for early identification of pregnant women with the help of trained and untrained dais will result in improved antenatal coverage of pregnant women. Identification of pregnancy related risks at early stages and referral of such cases to specialists form an important part of this package of services.

- All women in the reproductive age group will be educated about available antenatal services and the need to utilize such services.

- The number of pregnant women registered and the services provided in all health institutions will be closely monitored at all levels in the Health and Family Welfare department. PRIs will be involved in the monitoring process.

- Convergence of programmes and integration of services by establishing linkages between female health workers, Anganwadi workers, and trained dais in the villages will be strengthened.

- *Jan Mangal* couples will be involved in propagation and publicity of antenatal services. In this context the implementation of centrally sponsored scheme will be ensured.

6.11.5 Safe Delivery Services

6.11.5.1 One factor that contributes to rapid decline in maternal morbidity and mortality and infant mortality is the proportion of deliveries conducted in institutions. Institutional deliveries are not only safe but also promote health care seeking behaviour among women. In majority of states where the proportion of institutional deliveries is high, the proportion of deliveries conducted in private nursing homes is also high. In Rajasthan, the private health sector has limited presence and is largely confined to major cities. Given this, it is unrealistic to expect major changes in the proportion of institutional deliveries in the foreseeable future. Efforts, however, have to be made to make the deliveries, clean and safe, even if conducted at home. Serious efforts will therefore be made to ensure that all deliveries occur in health institutions by the year 2020.

- Each village in the state will be provided with a trained *'dai'* by the year 2001.

- To have a trained *'dai'* in each village, *'dai'* training programme will be initiated. Females of the villages who are at least 8th standard pass will be selected and imparted training. The state government will provide stipend to them during training and on completion,

these trained *'dais'* will provide services in their villages. The trained *'dais'* will be allowed to charge a fee for the services. Further, a provision will be made to promote *'dais'* as ANMs after seven years of good performance.

- Each year 100 PHCs will be strengthened with all necessary equipment and trained manpower to provide round-the-clock services of safe and clean deliveries.

- Programme of production and distribution of disposable delivery kits to pregnant women, including social marketing will be reviewed and expanded to achieve maximum coverage. By the year 2000, each *'dai'* will be provided with a disposable delivery kit, and will be replenished regularly.

- The department will strengthen the referral system to attend to complications related to delivery. By the year 2000, all the first referral units will be fully equipped and services of trained specialists will be made available.

- Funds will be made available to Panchayats for providing transport facility to women requiring referral services in remote and inaccessible areas.

- Mother child health camps will be organized each month in each village on a fixed day involving anganwadis (AWWs) and women health groups.

- Cooperation of private institutions will be sought to increase institutional deliveries.

- Facilities for institutional deliveries will be provided in ayurvedic hospitals having trained female vaidya.

6.11.6 Child Health

6.11.6.1 In the population policy, it is necessary to include programmes and activities relating to health and development of children.

6.11.6.2 Following are the major strategies to improve infant and child health:

- Promotion of institutional and safe deliveries by trained *'dais'*.

- Improvement in the nutritional status of mothers through supplementary feeding and to increase birth weight of child to a minimum of 3 kgs.

- Achievement of hundred percent immunization for eradication of polio, tetanus and measles.

- Reduction in the current prevalence of 11 percent of diarrhoeal diseases by providing information about ORS to all families; and by ensuring proper identification of symptoms of dehydration and wide publicity of home available oral rehydration therapy.

- One third of deaths among children below five years are due to ARI. All the parents should be educated about ARI, its control and management. For this purpose a special campaign, through IEC will be launched to ensure active participation of ISMPs, private allopathic doctors and NGOs/VOs.

- For controlling diseases in children caused by malnutrition, Vit.A will be administered to all children, and IFA tablets and iodized salts will be provided to all malnourished children.

- Appropriate information regarding child feeding practices will be widely provided to reduce severe malnutrition among children and more children will be covered under supplementary nutrition programme.

- All hospitals, dispensaries, and mother and child health Centres will be made 'Baby friendly'.

- Effective systems will be developed to reduce child labour.

6.11.6.3 Coordinated and programme Centered approach is essential for implementation of child survival strategies. Involvement of all sectors, particularly the health and nutrition sectors are important. Moreover, attention will be laid on coordinated implementation of ICDS, nutrition, family welfare and women and child welfare programmes.

6.11.6.4 Department of health and family welfare will work for information dissemination on different issues of RCH in addition to ICDS programme.

6.11.6.5 Departments of education, water supply, health and social welfare are the departments that contribute to child survival. Efforts will be made to coordinate programmes and activities of these departments.

6.11.7 Family Planning Services

Population policy can be meaningful only when it follows a welfare approach and is consistent with peoples' aspirations. The focus of the policy therefore, is to educate the families, particularly the couples in reproductive ages, about different methods of family planning and provide them need-based services as per their expectations. There is no place for coercion in providing these services. Following are the major components of the strategy:

- Family planning is exclusively a decision taken by the family voluntarily wherein they decide to opt for one or the other method according to their own needs.

- In the overall concept of family welfare, the problem of population will be dealt with as part of the RCH package.

- Basis of this policy is to inform and educate the families from time to time about the different methods of family planning ranging from sterilization to spacing methods.

- Surveys using scientific methods, will be conducted to assess couples perceptions,

expectations, needs and desired family size and accordingly the family planning services will be made available to them.

- On the basis of the assessment of unmet need collected in these surveys, implementation plans will be formulated at all levels (villages, community, block, district and state).

The success of the programme will depend on coordinated efforts of different sectors and elimination of gender discrimination, IEC, education specially women education, women empowerment and timely supply of contraceptives as per demand and regular and close contact of the health worker with the family. Special emphasis will be given to these factors while implementing the strategy.

6.11.8 Promotion of permanent and temporary methods of family planning

6.11.8.1 The ratio of male to female sterilization is low in spite of being safe and less expensive. For promoting male participation in the family planning programme, wide publicity will be given and efforts will be made to increase proportion of male sterilization to 30 percent of all sterilization acceptors. Special attention will be given to couples with two children. Apart from this, the following are the major aspects of the strategy:

- Reduce the proportion of women having three or more births.

- Promote sterilization services through private service providers.

- Train medical doctors including private practitioners in new and safer techniques of sterilization.

- Give wide publicity to *'Raj Laxmi Yojna'*.

6.11.8.2 Use of spacing methods is only 13 percent in the state, which is very low. Low awareness about spacing methods, social inhibitions, lack of determined will, limited access to source of supply and perceived or real side effects are some of the important reasons for low acceptance. In the background of low age at marriage and at first delivery, promotion of spacing methods can reduce fertility and mortality and prevent RTIs.

6.11.8.3 Following are the major aspects of the strategy to promote spacing methods:

- Wide information dissemination campaign will be launched to provide correct information on spacing methods.

- Screening procedures will be systematized and standardized for oral contraceptive and IUD users. A full range of information and counseling services on side effects and their management will be provided.

- Participation of practitioners of Indian System of Medicine and private practitioners will be sought.

- For reliable supply of contraceptives social marketing will be promoted. *Jan Mangal and* community based distribution systems will

be streamlined and consolidated in the entire state.

- Interpersonal communication and counseling will be promoted through NGOs/VOs and community leaders.

6.11.9 Infertility

The aim of the Family Welfare Programme is not merely to reduce family size, but to promote the concept of small and happy families. About 10 percent of couples in Rajasthan face the problem of infertility and suffer from social stigma attached to it. Although both men and women could be equally responsible for infertility it is women who, often, received all the blame. Rigid customs do not allow participation of such women in some rituals and functions. A sense of personal failure, fear of insecurity, and loss of ambition and drive are other psychological costs associated with the infertility problem. It is, therefore, necessary to address issues related to infertility as an integral part of the RCH programme.

- Simple instruction material on how to treat couples with infertility problems will be prepared and distributed to all health institutions.

- Short training programmes will be conducted for different categories of health workers, doctors, gynecologists, and ISM practitioners in both public and private sectors on infertility management, with special emphasis on up-gradation of technical skills.

6.11.10 Reproductive Tract Infections

6.11.10.1 Reproductive tract infections constitute one of the most neglected aspects of reproductive health. Even a reliable database is not available to estimate their prevalence. There are also considerable technical and cost related problems associated with the detection of reproductive tract infections. Some of the infections are asymptomatic and are, therefore, not easily detectable and the lab tests require intense managerial effort, professional skills and considerable amount of money. Given all these problems, lack of reliable information on the prevalence of some of the RTIs will remain a problem. However, most prevalent infections can be detected using the syndromic approach with a reasonable degree of accuracy.

6.11.10.2 With the help of female health workers and NGOs databases will be created in all the districts to know the extent of the prevalence of reproductive tract infections.

6.11.10.3 Female health workers, lady health visitors and medical officers, service providers of NGOs and ISM practitioners will be trained in infection prevention practices and management of infections.

6.11.10.4 A special provision will be made for supply of medicines to all the districts and community health Centres.

6.11.10.5 The department will cover all the districts in the state in a phased manner and

will substantially reduce the prevalence and incidence of reproductive tract infections.

6.11.11 Improvement in the Quality of Services

6.11.11.1 Improvement in the quality of services is essential for the success of the population policy. Following are the major components of the strategy:

- Availability of doctors and health workers at a particular place and time.
- All the health workers providing family welfare services should have sufficient technical and management skills, dedication and motivation in performing their duty.
- Necessary environment for providing quality services that include sufficient resources, necessary equipment, medicines, dressing material etc.
- Community participation in the programme.

6.11.11.2 Strategies for ensuring availability of doctors, and health workers are as follows:

- Free lodging facilities at all PHCs and sub-centres.
- The multipurpose health workers will be provided with a female assistant.
- Multipurpose health workers and the female assistants, as far as possible, will be posted to towns, closer to their homes.
- The primary health services will be made accountable to local bodies to ensure local level appointments and control.
- The task of primary health care in remote areas will be assigned to NGOs on experimental basis.
- Efforts will be made to start a revised three-year course on public health for primary health care after seeking approval from Medical Council of India.
- Doctors will be posted at PHCs during internship to serve for a minimum period of 6 months.
- To ensure that on first posting, the doctors will be posted in rural areas for a minimum period of three years.

6.11.11.3 The merit of any programme depends upon those who manage and execute it. Therefore, it is essential to ensure that programme managers and field functionaries possess the right aptitude and necessary technical, management, communication and counseling skills. Along with this, it is also required to upgrade skills of NGOs, elected representatives, leaders and opinion makers to ensure participation of the community. Financial provisions for this purpose will be made.

6.11.11.4 For strengthening all PHCs/SCs following resources will be provided under different schemes in a fixed time frame:

- Construction of the building of the Centre and staff residence.

- Necessary equipment.

- Ensured supply of medicines, dressing and other material.

- Increased mobility of doctors and other workers.

6.11.12 In patriarchal society like ours, important decisions are taken by men folk. However, low proportion of male sterilization indicates that male participation in the family welfare programme is low. Following strategies will be adopted to increase male participation:

- Male participation should not be limited to fathering children or decision regarding use of contraceptives. They must know the problems associated with pregnancy so that they can extend full support in looking after the reproductive health needs of their spouse.

- Active participation of the male members in family welfare programme will be enhanced. In urban areas men are aware and conscious to some extent, but in rural areas the situation is quite different. For this purpose attention will be paid to remove social, cultural, psychological barriers and appropriate family welfare education and IEC strategy will be developed.

- For ensuring effective participation of men, management of their specific health problems such as venereal diseases, impotency etc. will be made important part of the policy document.

6.11.13 The emphasis on micro-planning in the context of the 'Target free approach', has increased since its inception in 1995. Plans therefore will be prepared on the basis of estimation of unmet need at local level. This will provide basic information on those seeking family planning and reproductive health services. Through this approach that is based on survey, field workers will be provided with latest information on target groups who need to be contacted and provided services.

6.11.14 Social Marketing

6.11.14.1 The concept of social marketing will be an effective component in the implementation of the population policy. The organized and corporate sector, have pioneering experience in this field. Using technical skills of this sector effort will be made to fulfill the requirements of the different segments of the society. Corporate houses will be involved for achieving this purpose.

6.11.14.2 Following are the major components of social marketing strategy:

- A number of companies have made their presence felt in commercial marketing of ORS and contraceptives. Cooperation of private sectors will be taken in social marketing of

different contraceptives including condoms in different areas and segments of society.

- Efforts will be made to market ORS and contraceptives through social service providers such as *'Dais'*, barbers, grocery shop owners, tea and pan shops etc.

- The system of community marketing will be adopted in remote and inaccessible areas.

6.11.15 Programme Management in Urban Areas

6.11.15.1 Primary health structure is available in rural areas for family welfare and mother and child health services. Similar structure is not available in urban areas. Considering the rapid migration of rural folk to urban slums such structure is much needed in cities. Following are major components of the strategy to achieve this:

- Provision of one ANM or a nurse for 20,000 population.

- One Reproductive Health Centre for a population of 200,000.

- Such centres will also be set up in slums and areas of deprived sections of society.

- Encourage industrialists for ensuring private sector's participation in this endeavor.

6.11.15.2 Following are major components of the strategy to seek cooperation of private sector:

- Industrial houses to provide health services at district and block headquarters.

- Defined geographical areas will be linked to the health services provided by the Industrial Houses to provide family welfare and RCH services.

- Adoption of remote rural areas by the industrial houses to provide mobile services until regular health service delivery system is in place.

6.11.16 Development of Human Resource

Development of the capacities of human resources in accordance with new population policy is essential. To achieve this, appropriate changes will have to be made in the training programmes of the functionaries at all levels . The field functionaries will, particularly, be reoriented and trained in latest techniques. Qualitative changes will be brought in the programmes of SIHFW and regional and district training centres. A training strategy will be evolved for this purpose. Changes in accordance with different components of the policy, will be made in medical training. In these training programmes special attention will be paid to abortion, sterilization, infertility and IUD etc.

6.11.17 Research and Development

The concept of this policy is to bring changes and improvement on the basis of experiences. Realizing the elements of continuity and integrated processes inherent in the field of research and development, the state Population

Resource Centre (PRC) will undertake continuous evaluations, baseline surveys, develop and test different processes and formats, collect primary data and undertake operations research. The centre will collect information about new experiments in the country and abroad and disseminate it to health workers at all levels. The centre will provide advice and suggestions to the state government regarding population programme management. Specialists in different fields will be attached with the centre. The centre will have autonomy in decision-making and will be provided with adequate financial resources.

6.11.18 Evaluation and Monitoring

6.11.18.1 This programme will have time bound objectives. The knowledge of achievement level is essential for ensuring timely completion of the tasks. Apart from this, continuous evaluation is essential for making mid term changes and improvements, if found necessary.

6.11.18.2 The main focus of this policy is on couples in reproductive age group. Emphasis will be placed on timely fulfillment of their needs for family planning and reproductive child health services.

For these components, a strategy of regular surveys, transparent information system and continuous evaluation by independent agencies will be adopted. Services of skilled male and female investigators will be taken and a computerized information system, a data bank, a reliable non- governmental evaluation agency and systematic communication system will be put to use for achieving the objectives. The system will operate at all levels.

6.11.18.3 In evaluation and monitoring, attention will be paid equally to quantitative and qualitative aspects.

6.11.18.4 Monitoring and evaluation work will be different from the activities mentioned under the heading "Research and Development".

7. Implementing Structure

7.1 System

7.1.1 In order to bring about a change in the present situation, the management of service delivery system will be made client-oriented for effective implementation of this policy. It has to be ensured that the components of family planning and mother and child health are integrated.

7.1.2 For ensuring better management, the programme implementation should be evaluated on a continuous basis so that problems can be identified and resolved concurrently. This has been neglected for some time and hence serious thinking and developmental oriented efforts are needed.

7.1.3 The ultimate aim of the policy is to accelerate the functioning of implementing structure so that a large section of population needing these services, could avail them. We expect increase in demand of these services in future.

7.1.4 In this policy draft an analysis of the functioning of a group of implementing systems have been done, after decentralizing their functioning. Most of these systems are already in place and few changes have been suggested in accordance to the specific needs.

7.1.5 For adaptability of various strategies, streamlining of programme management will be done with particular emphasis on availability of a package of services, choice of contraceptive methods, programme based management, revised organizational structure, micro-planning and peoples participation.

7.2 Organizational Structure and System

7.2.1 Over the past four decades the Department of Medical, Health and Family Welfare and other departments have achieved notable successes. However, several areas of concern remain to be attended to. The programme has witnessed the addition of new elements and expansion and improvement of existing elements. A vast network of health institutions has been created to serve all villages and urban areas. The organization's structure, given its multiplicity of objectives and tasks, has become complex. Such a complex set of tasks cannot be attended to with a centralized approach.

7.2.1 Participation of all health staff in planning and implementation, and involvement of local leaders and personnel concerned with other development programmes is essential to achieve the stated objectives. Keeping this in view, the department has initiated the process of

formation of committees at different levels. These committees will be reconstituted and strengthened.

7.2.2 A State Population Council has been constituted with the Chief Minister as Chairperson, and Cabinet ministers of Development Departments, Leaders of Opposition Parties, the Chief Secretary, Secretaries of Development Departments and NGO representatives as members. The council will review the programme strategies and the coordination linkages between departments, and provide direction to the programme. The state PRC will be the permanent secretariat of the Council that will be responsible for implementing the policy.

7.2.4 At the local level, District family Welfare Coordination and Monitoring Committees will be constituted with Zila Pramukh as chair person. Elected representatives of Zila Parishad, MLAs/MPs representing the district, and district level officers of health, ayurved, education, agriculture, and ICDS departments, representative of NGOs, and women social workers will be the members. The main function of the committee will be to promote innovative schemes, to review programme performance, to suggest ways to improve quality of services, and to mobilize additional resources for the programme. The committee will also work to redress the grievances of people. The District Collector will have an important role in this committee. The committee constituted at the block and village levels will also be involved in programme implementation.

7.2.5 Block and village committees will be headed by the head of Panchayat Samiti and Sarpanch respectively. These committees will have officers, employees of various departments and people's representatives as members. These committees will review the programmes and give suggestions for their effective implementation.

7.2.6 The Family Welfare Programme also involves social engineering. It just cannot be implemented solely as a medical programme. Therefore selected officers will be deputed in District Family Welfare Bureau for five years for effective implementation of the programme.

7.2.7 Different systems such as the management information systems, system of procurement and distribution of equipments etc. and their maintenance will be streamlined to suit the programme and local needs. The department will make continuous efforts to optimize the available resources and improve work efficiency.

7.2.8 Number of schemes like Jan Mangal, Swasthya Karmi, Micro-planning and Vikalp have been initiated in the state for ensuring community participation in programme implementation and in improving the achievement level. Operations Research can provide significant insight in finding alternative approaches for achieving the objectives. The department will encourage NGOs/VOs to take up Operations Research Studies to increase demand, reach and quality of services. The experiences gained in

this process will be documented and disseminated widely. This will provide an opportunity to introduce innovations in special programmes.

7.3 Role of various Departments

The State departments, PRIs and peoples representatives along with the Department of Medical and Health will be responsible for implementation of the population policy.

1. Home Department

1. Strict enforcement of "Child Marriage Restraint Act".

2. Regular dissemination of information regarding small family norm, family planning, mother and child health, immunization etc. to police personnel.

3. A five minutes slide/documentary to be shown in every cinema hall before the beginning of cinema show. The Home Department will ensure strict implementation of this directive.

4. Population education will be made part of police training.

2. Department of Food and Civil Supplies

1. Printing of small family norms on Ration cards. The IEC Bureau will provide slogan and design for this purpose.

2. Distribution of Nirodh by all the ration shops (fair price shops).

3. Display of messages of family planning and RCH through posters, wall pictures, wall stencils, tin plates etc. in and around the fair price shops. The IEC Bureau will provide material for this purpose.

3. Department of Panchayat and Rural Development

1. Review of the family welfare programme should be a permanent agenda in the meetings of the District Council, Panchayat Samiti, Gram Panchayat and Gram Sabha.

2. The basic responsibility of the implementation of family welfare programme will be with the Gram Panchayat.

3. If the employee of PHC, sub-centre, ayurvedic dispensary located in a panchayat area, is not present at head quarter for providing continuous services, the Sarpanch can report such matters to the District Collector.

4. At least two pages will be set-aside in the magazine "Rajasthan Vikas" for the material provided by IEC Bureau.

5. Panchayat should regularly review the implementation of family welfare programme, and if the officials are not providing services required according to the needs, Panchayat should send their feed back to higher officials.

6. Teachers of primary schools and Gram Sevaks should organize monthly discussions on consequences of increasing population.

4. Department of Cooperatives

1. Cooperative societies should encourage and inspire their members to opt for small family norms.

2. Publicity of family welfare programme will be carried out through wall writings, wall pictures, hoarding, pamphlets at the offices of all the village cooperative societies. Director, IEC will provide messages for this purpose that can be displayed on milk cans by the milk co-operatives.

3. In training programmes organized by State and District Co-operative Federations, participants can be oriented to the family welfare programme.

4. Family Welfare should be a permanent agenda in all the general body meetings of co-operative societies.

5. The publicity units of co-operative federations and its departments should integrate the publicity of family welfare in their programme.

6. Messages on family welfare should be printed on the pass books/ cards and other materials given to their members by the cooperative societies.

7. Co-operative societies and other provision shops should distribute 'Nirodh' on commercial basis.

8. Organize orientation programmes for the members of co-operative societies on the subject of family welfare.

9. Institute an award for best performing co-operative society in family welfare.

5. Department of Transport

1. Display of family welfare messages on the vehicles of Rajasthan Road Transport Corporation. Private vehicle owners should also be encouraged to display the messages on their vehicles.

2. The family welfare messages should be printed on all permits and receipts issued by the department.

6. Department of Urban and Local bodies

1. Proper publicity of the family welfare messages through posters, tin plates and other materials provided by the family welfare department.

2. Effective participation of elected members in the implementation of family welfare programme.

3. Discussion on family planning as a local agenda in the meetings of local bodies.

7. Department of Education

1. Family Welfare as a subject to be introduced

in the curriculum of schools and colleges for providing information to students about reproductive health and population.

2. Organize debate/seminar, elocution competitions on the problems of population in schools and colleges.

3. Create awareness about the dangers of increasing population and emphasize family welfare education in Total Literacy Campaign (TLC) and Post literacy Campaign (PLC).

4. To pay more attention to female literacy and education.

5. To organize programmes for reproductive health education of adolescents in schools and colleges through medical and health department.

8. Department of Revenue

1. *Patwari* and other field officials/workers should motivate people, who come in their contact during the course of work, to adopt small family norms.

9. Department of Labour

1. The ESI Health system should be made an active partner in the family welfare programme and targets should be fixed in this regard.

2. Cooperation of trade unions should be sought in motivating workers to adopt the small family norm. Joint workshops involving industry manager, family welfare department and trade unions, should be organized time to time.

3. The ESI Hospitals and dispensaries should in addition to FW services also include counseling and motivation activities.

10. Department of Women and Child Development

1. Programmes of self-employment for women and girls should be taken up and family welfare and reproductive health education should be integrated with these programmes.

2. Different agencies engaged in women's development should publicize and propagate the message of small family norms and RCH.

3. AWW should be made in-charge of contraceptive depot and she should motivate and encourage couples who have more than two children and are yet to adopt a family planning method.

4. Nutrition and health programme, which are looked after by AWW should be monitored closely. A system based birth weight should be adopted to make this programme more effective.

5. AWW should organize a discussion on mother and child health care every month.

6. Family Planning and RCH related problems should be discussed openly in the meetings

of 'Mahila Mandals' in the presence of ANM. The ANM has to solve the problems after consulting with the Medical and Health Department.

7. AWW should be made depot holder for contraceptives and ORS.

11. Department of Ayurveda

- Publicity and education on family planning and RCH services provided.
- Ayurvedic dispensaries should also function as depot and distribution centres for contraceptives.
- Department should develop programme for mother and child health based on ayurveda system and implement it.
- Motivate couples with two or more children and who have not adopted family planning. ayurvedic dispensaries will set performance objectives for this purpose.
- Refer emergency cases of delivery and child health to the referral centres of the Department of Medical and Health.

12. Information and Publicity Department

1. Organize discussions involving media persons on population problems and to seek their cooperation in government's publicity efforts.
2. Publicity through mobile vans of the department.
3. Provide technical help to family welfare department whenever required, in developing messages and other publicity materials.
4. The Regional officials of the department should integrate messages on family welfare in their programmes.

13. Department of Agriculture

1. Discussion on family welfare in all meetings of farmer groups organized in the area.
2. Incorporate family planning messages in all activities of agriculture extension and watershed development programmes
3. Implement the family welfare programme in areas where GOIs watershed schemes are operational.

14. Department of Public Health Engineering

1. Printing of family planning messages on water bills.
2. Printing of family planning messages on water tanks and Ground Level Reservoirs (GLRs).

15. Department of Industry

1. All industrial units of the state should make the family welfare programme an integral part of their labour welfare programme. They should take up necessary steps for providing family welfare services to workers as well.

2. The Industrial Federations should organize seminars and workshops on a regular basis, to create an environment for small family norms.

16. Department of Youth affairs

1. Activate NYKs for creating awareness among rural youth on small family norms and RCH.

2. Integrate family planning messages with other activities of the department.

17. Department of Forest and Environment

1. Integrate the family planning message in all their activities to high light the impact of increasing population on environment.

18. Medical and Health Department

1. Set family welfare performance objectives for hospitals, medical colleges, clinics, district hospitals and health centres.

2. Strengthen the services for institutional delivery and safe abortion services.

3. Integrate family planning counseling with all other health services.

4. Ensure quality of services.

19. District collector

1. Organize review meetings of district family welfare committee and to provide guidance and leader ship to the programme.

2. Coordinate work of all departments involved in the programme implementation. The services provided by the department will be monitored at the level of collector.

3. Involve elected representatives, NGOs and community for creating conducive environment for the family welfare programme.

4. Ensure that the department of medical and health makes all arrangements for service delivery to fulfill unmet need of family planning in the district.

5. Effective monitoring of the services and to ensure that no area remains uncovered by family planning services in the district.

20. Department of Personnel

1. Employees of the state government in different training institutions on the subject of population increase, state government's initiatives and their roles and responsibilities in implementation of family welfare programme.

For effective implementation of the activities, all the departments will have to develop a system to make maximum utilization of the services of the employees. The departments will make internal provisions in their budgets for these activities. The department of medical and health will function as a nodal agency for co-ordination activities, apart from providing services.

8. Summary

This policy draft deals with the structure, implementation, monitoring and evaluation of the RCH programme. It is a reflection of State Government's commitment for over all welfare of the people of Rajasthan. At every level from secretariat to level of panchayat, people's co-operation will be sought and ensured for implementation of this policy. Although the primary responsibility on policy implementation is of the department of Medical, Health and family welfare, it can not succeed without full co-operation and active support from other departments and sectors i.e. department of Education, Women and Child Welfare, Social Welfare, NGOs/PVOs and Corporate sector. The Government will make every possible effort to ensure the success.

Abbreviations

1.	ANC	-	Ante-Natal Care
2.	ANM	-	Auxiliary Nurse Midwife
3.	CBR	-	Crude Birth Rate
4.	CDR	-	Crude Death Rate
5.	CPR	-	Contraceptive Prevalence Rate
6.	DPEP	-	District Primary Education Programme
7.	EC	-	Eligible Couple
8.	EGR	-	Exponential Growth Rate
9.	IMR	-	Infant Mortality Rate
10.	ICDS	-	Integrated Child Development Services
11.	IEC	-	Information, Education and Communication
12.	IUD	-	Intra Uterine Device
13.	MMR	-	Maternal Mortality Rate
14.	MTP	-	Medical Termination of Pregnancy
15.	NFHS	-	National Family Health Survey
16.	ORS	-	Oral Rehydration Salts
17.	PHC	-	Primary Health Centre
18.	PNC	-	Post Natal Care
19.	RCH	-	Reproductive and Child Health
20.	SB	-	Still Birth
21.	SC	-	Sub Centre
22.	TFA	-	Target Free Approach
23.	TFR	-	Total Fertility Rate